From: Scott Chad D
To: Brandon Miller; Bowlin Royce A
Cc: Jett Chantay; randy.roddey@gobhi.net
Subject: RE: Conversation regarding KEPRO
Date: Wednesday, November 22, 2017 9:55:00 AM

Thanks for putting this together Brandon, this is good information. As we receive feedback from providers about Kepro, I like to work first with the provider around the concerns to 1) validate the concern (usually asking for specific examples, which you have provided 2) Determine the primary issue (is it provider, is it Kepro, is it something else?) and 3) Provide technical assistance back to the appropriate party.

I've separated your concerns below and provided a response for each. Please let me know if I missed something or if you need additional information about any of your concerns.

Please feel free to send me additional concerns in the future.

Thank you

Concern 1: Failure to inform program of status updates

Once emailed to KEPRO, we receive a response stating "We have received your authorization request! Barring any issues or omissions, we will review within 10 business days of 11/14/2017. Thank you and please let us know if you have any questions or concerns."

The only way we know that it was approved is that 1) MMIS allows us to bill the new period and 2) We will receive a OHA Service Authorization with the approved dates (this letter is very inconsistent in how long after it is mailed)

Response 1: You can use the Provider Web Portal to view approved authorizations, submit claims and more. I always encourage providers to become familiar and use the portal rather than relying on mail or playing claim roulette.

Access the portal at https://www.or-medicaid.gov

- **If you need a PIN:** Email your provider name and Oregon Medicaid provider number to Provider Services (800-336-6016).
- **If you are a current user and need access to certain features, or need your password reset:** Contact your office administrator or Provider Services.
- **If you need to change your office administrator:** Login as the administrator and update using Account Maintenance. If you cannot login as the administrator, contact Provider Services.

Questions? View our frequently asked questions and troubleshooting tips or contact Provider Services.

Learn more at http://www.oregon.gov/oha/healthplan/Pages/webportal.aspx

Concern 2: Example: PGH submitted a Prior Authorization Request in May of 2017 2 weeks prior to the previous authorization's expiration date. We never received a response from

KEPRO either way and MMIS it was approved and we continued to bill on client. I began to enquire KEPRO about the service authorization we never received, attempting to determine the expiration date of the current authorization. KEPRO at this point said they had 'Denied' the authorization as it was missing documents or had incorrect signature (see below). This was the end of October/beginning of November. This was the first time KEPRO had notified PGH of this. This exact example is a common scenario.

Response 2: Kepro has ten days to review a request from the date of submission. Review means, the request is reviewed for completeness and compliance with OAR. The request is then sent for a medical appropriateness review and determination of approval, reduction or denial. When a coverage decision is made, Kepro enters that into MMIS. MMIS issues a letter (prior authorization approval, reduction or denial and in cases of denial, a member notice of action). This is an automated function and occurs when any action is taken on a PA. To resolve this, I would again encourage use of the provider portal.

I will also follow up and review the PGH approvals to make sure the notifications were sent or if there was a technical issue with MMIS. If you have the POC number for any authorizations you didn't receive notice about, that would be helpful and I'll go into MMIS and see what's going on.

Concern 3: Appear to lack understanding of applicable OAR's as they relate to Residential programs, documentation and general understanding of MHA's.

After going through process described above, we discovered that several client's authorization requests were 'denied' due to the LOCUS not being signed by a QMHP, while that document can be completed by a QMHA individual. (kind of a moot point as LOCUS are no longer required)

Major discrepancy between KEPRO's understanding of and Residential providers understanding of Mental Illness and 'what diagnosis' is appropriate for residential care. KEPRO had denied authorization on the basis of diagnosis for diagnoses of PTSD, Hoarding/OCD, Psychosis NOS, etc :

OAR 309-035-0105(40) "Mental or Emotional Disorder" means a primary Axis I or Axis II DSM diagnosis, other than mental retardation or a substance abuse disorder that limits an individual's ability to perform activities of daily living.

OAR 309-035-0163 (7) ……Be assessed to have a mental health disorder or a suspected mental health disorder

Response 3: It's common for providers to confuse licensing and certification rule with Medicaid payment rules. The 309 rules are the rules providers must follow to maintain licensing and/or certification (obtain a credential). The Medicaid payment rules are found in the **410-172-0000** rule set. Kepro is contractually required to follow the 410 rules when reviewing requested services.

The four rules most applicable to residential services are;

410-172-0630
Medically Appropriate

410-172-0650
Prior Authorization

410-172-0720
Prior Authorization and Re-Authorization for Residential Treatment

410-172-0700
1915(i) Home and Community Based Services

Because Oregon's residential services are based on the needs based criteria in our 1915(i) Medicaid state plan, the procedure codes used to fund residential services are not "paired" with a diagnosis. Assessment of the persons need determines whether or not a level of care or place of service is medically appropriate or if that person can receive services and supports in a less restrictive setting. For the diagnosis mentioned above, Kepro likely made determination based on the person's needs rather than diagnosis.

I'll follow up with Kepro and ensure they are making needs based determinations versus diagnosis (code pairing) based determinations.

Concern 4: One of our clients was being reviewed for her appropriateness to placement and at one place in the MHA it mentioned that once this client was back in residential her "MS" returns to baseline. The KEPRO caseworker assumed that was Multiple Sclerosis and had KEPRO doctors investigating if this could impact her mental status etc. This diagnosis is not mentioned or listed anywhere in the MHA. The therapist who did the MHA used "MS" to describe mental status. Concerning how far KERPO went to denying services and using resources before a simple clarification call/email was made.

Response 4: Sounds like a legitimate oversight and I will follow up with Kepro on this. I'll request they verify acronyms and abbreviations prior to making coverage determinations.

Concern 5: Been deemed unfit for Residential level of care by KEPRO case manager due to client not wanting to 'participate in treatment'. Yet it seems like the Choice Model implies that the client has the right to choose which services they do or do not want to participate in.

Response 5: People do have choice in the service and supports they receive but there are limitations to choice as to the place of service or provider type. If a person chooses to receive counseling, they have that right, but only in a setting that is medically appropriate and by a provider that can meet their healthcare needs. They may want counseling from a psychiatrist in a hospital, but a counselor in an outpatient setting can meet their healthcare needs, so the provider type and place of service can be denied. Kepro, in most cases of residential denial is denying the place of service and/or provider type rather than the benefit.

Concern 6: Through all of this, when KEPRO have denied recent prior authorization requests, they were just cut off in MMIS without prior notice and funding for clients ended. We spent a week of phone calls and emails to reestablish authorizations to bill for an additional 60 days on each client pending additional documentation to "appeal" their decisions. Our understanding is that if KEPRO determines that the client is no longer eligible to be at RTF level of care, they will authorized an additional 60 days while efforts are made to get the client to an "appropriate" level of care as deemed appropriate by KEPRO case manager.

Response 6: That is correct, Kepro can issue up to 60 days of continued stay for individuals denied continued stay in a residential setting. Kepro has been directed to provider 60 days continued stay for AFH/RTH/F and 90 for SRTF and extensions of those stays until the person has transitioned into an appropriate service or support.

I'll reiterate this expectation with Kepro and please let me know if you or a resident experiences a denial of continued stay without a continued stay extension.

410-172-0720
Prior Authorization and Re-Authorization for Residential Treatment

(1) The Authority does not consider a request for a fixed episode of care or standardized length of stay to be medically appropriate. Requested length of stay shall be based on an assessment of individual need and the medical appropriateness of the proposed time for treatment.

(2) Residential treatment is intended as an outcome-based, transitional, and episodic period of care to provide service and supports in a structured environment that will allow the individual to successfully reintegrate into an independent community-based living arrangement.

(3) Residential treatment is not intended to be used as a long-term substitute for lack of available supportive living environment in the community.

(4) Authority licensed residential treatment programs are reimbursed for the provision of rehabilitation, substance use disorder, habilitation, or personal care services as defined in these rules.

(5) The Division shall authorize admission and continued stay in residential programs based on the medical appropriateness of the request and supporting clinical documentation.

(6) Prior authorization requests for admission and continued stay may be reviewed to determine:

(a) The medical appropriateness of the admission for residential services provided;

(b) The appropriateness of the recommended length of stay;

(c) The appropriateness of the recommended plan of care;

(d) The appropriateness of the licensed setting selected for service delivery;

(e) A level of care determination was appropriately documented.

(7) If the Division determines that a residential service prior authorization request is not within coverage parameters, the provider shall be notified in writing and shall have ten business days to provide additional written documentation to support the medical appropriateness of the admission and procedures.

(8) If the reconsidered decision is to uphold the denial, prior authorization shall be denied.

(9) The provider may appeal any final decision through the Division administrative appeals process as described in OAR 410 120-1560 through1875.

(10) Upon denial of a prior authorization request for continued stay, the Division shall authorize payment for up to 60 days of continued stay for the purposes of supporting transition management and planning for the recipient.

(11) The Division shall determine re-authorization and authorization of continued stays based upon one of the following:

(a) The recipient continues to meet all basic elements of medical appropriateness and;

(b) One of the following criteria shall be met:

(A) Documentation that the treatment provided is resulting in measurable clinical outcomes but that the recipient is not sufficiently stabilized or yet developed the skills necessary to support transition to a less restrictive level of care;

(B) The recipient has developed new or worsening symptoms or behaviors that require continued stay in the current level of care;

(12) Requests for continued stay based on these criteria shall include documentation of ongoing re-assessment and necessary modification to the current treatment plan or residential plan of care.

From: Brandon Miller [mailto:brandon.miller@gobhi.net]
Sent: Tuesday, November 21, 2017 5:37 PM
To: Bowlin Royce A
Cc: Scott Chad D ; chantay.jett@gobhi.net; randy.roddey@gobhi.net
Subject: Re: Conversation regarding KEPRO

Royce,
As you have been informed by Chantay Jett of Wallowa Valley Center for Wellness, Pioneer Guest Home II, Inc. has been encountering significant difficulties with KEPRO as related to approving/denying Prior Authorization Requests. Please find bullet pointed issues below:

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Please feel free to contact me anytime should you want/need further information or documentation!

Thanks for taking the time to listen to our concerns Royce!

Best,

Brandon

"Watch your thoughts; they become words. Watch your words; they become actions. Watch your actions; they become habits.

Watch your habits; they become character. Watch your character; it becomes your destiny" - LAU-TZU (500BC)

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